DEPARTMENT OF THE AIR FORCE
UNITED STATES CENTRAL COMMAND AIR FORCES (USCENTAF)

1 February 2006

MEMORANDUM FOR ALL USCENTAF MEDICAL UNITS

FROM: USCENTAF/SG

SUBJECT: USCENTAF Policy on Vector-borne Disease Protection and Malaria Chemoprophylaxis

References: (a) USCENTCOM/CCSG Message, DTG 1/6/2005 5:12:00 PM, Subject: MOD 7 to USCENTCOM Individual Protection and Individual/Unit Deployment Policy
(b) Armed Forces Medical Intelligence Center Infectious Disease Risk Assessment for Iraq at http://www.afmic.dia.smil.mil/index.php (SIPRNET)
(c) CFLCC Policy Memo 04-61 (Change 2), 20 Mar '05—20 Mar '07
(d) AF/SG Memo, Prescribing Requirements for Mefloquine Use; 25 Jan '05
(e) CJTF-76/CC Memo, Malaria Chemoprophylaxis Program for US Forces; Apr '05

1. Effective immediately, all US military and civilian personnel under operational control of USCENTAF will adhere to the supplemental guidance for malaria chemoprophylaxis at Attachment 1.

2. Personal protective measures (PPM) must be used throughout the USCENTAF area of responsibility (AOR) for protection against vector-borne diseases, such as malaria, leishmaniasis, and sand fly fever. PPM include: 33% DEET repellent, permethrin-treated uniforms, and permethrin-treated bed nets/poles. A year-round requirement exists at all locations for all deployers to have three (3) tubes of 33% timed-release DEET insect repellent skin cream and permethrin pre-treated DCUs/BDUs and bed netting, treated prior to departing home station EXCEPT as indicated below:

a. Personnel will **not** deploy with bed nets/poles if deploying to: Al Udeid, Al Dhafra, Ali Al Salem AB, Baghdad International Airport (BIAP) – Sather Air Base, Balad, Bagram, Camp Doha, Jacobabad, Manas, Kirkuk, or Ali Base. These bases will maintain a 5% contingency stockage of pre-positioned bed nets/poles (along with permethrin for pre-treatment) for personnel forward-deploying to malaria risk areas.

b. Nomex uniforms will not be pre-treated, as permethrin does not bind well to the fabric.

3. Malaria chemoprophylaxis for USCENTAF forces stationed in **Iraq**:

a. Anti-malarials are **not required** for personnel deployed to Iraq based on current vector surveillance, disease trends, and AFMIC's assessment, Ref (b).

b. Chemoprophylaxis requirements may be initiated in specific areas if the disease threat changes. In that event, Chloroquine (300 mg base, 500 mg salt) is the anti-malarial of choice, given weekly beginning 2 weeks prior to departure and continuing for 4 weeks after permanently leaving a malaria risk area. Mefloquine {Check specific medical clearance guidance, Ref (d), one 250 mg tablet, should be given weekly, beginning 2 weeks prior to exposure and continuing for 4 weeks post exposure} and Doxycycline (100 mg per day beginning 2 days before exposure and continuing throughout 4 weeks after permanently leaving the malaria risk area) are authorized options for non-flying personnel; however, only Chloroquine, Malarone, and Doxycycline may be used for personnel on flight status. In the event that chemoprophylaxis is necessary for forward deployment, required medications will be issued in theater.

c. AF Public Health personnel {based on AFMIC guidance, Ref (b)} will continue to actively monitor Iraq's changing environmental conditions that could necessitate resumption of chemoprophylaxis in currently malaria-free areas.

4. Malaria chemoprophylaxis for USCENTAF forces stationed in areas **other than Iraq**:

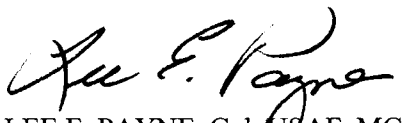
a. Refer to Attachment 1 to identify areas of risk, as well as type and duration of chemoprophylaxis regimen. Personnel who travel to or reside in a malaria risk area for **more than 24 hours** will begin malaria chemoprophylaxis**; exception: flight crews** on the ground **more than 72 hours** in a malaria risk area will begin malaria chemoprophylaxis.

b. Mefloquine is the anti-malarial of choice for all non-flying personnel assigned to or working in at-risk areas where Chloroquine-resistant malaria exists in the AOR outside Iraq (Follow guidelines in Attach 1). Specific Mefloquine prescription guidance and documentation requirements are listed in Reference (d). Additional Mefloquine prescription tools may be found on the CENTAF CAOC website. Doxycycline is the anti-malarial of choice for personnel on flight status in Chloroquine-resistant areas. Routine use of doxycycline for malaria prophylaxis of non-flying personnel is not recommended.

c. Terminal chemoprophylaxis with Primaquine is required after use of primary chemoprophylaxis. Begin treatment with Primaquine, 15 mg (as base)/day for 14 days upon return to home station and/or permanent removal from a malaria risk area. Glucose 6-phosphate dehydrogenase (G6PD) status must be determined and documented prior to treatment. Medical monitoring of patient is highly encouraged. This is to be taken in conjunction with ongoing primary malaria chemoprophylaxis.

d. All personnel should deploy to these areas with sufficient chemoprophylaxis for the duration of their deployment. Commanders are authorized to extend a year-round chemoprophylaxis policy if threat assessments indicate there is an extended seasonal risk. Personnel will be instructed on arrival when to begin anti-malaria medications if the local threat is greater than indicated in published instructions.

5. POC is USCENTAF(M)/SGP, Col Chris S. Crnich at chris.crnich@shaw.af.mil / DSN 312-965-4221 or uscentafsg@shaw.af.mil / DSN 312-965-4373. This policy memo supersedes all previous editions.



LEE E. PAYNE, Col, USAF, MC, SFS
USCENTAF Surgeon

1 Attachment:
USCENTAF/SG Guidance

Attachment 1 to USCENTAF/SG Memorandum, 1 February 2006, USCENTAF Policy on Vector-borne Disease Protection and Malaria Chemoprophylaxis

USCENTAF/SG GUIDANCE FOR MALARIA CHEMOPROPHYLAXIS

1. Malaria risk at USCENTAF deployment sites varies by season and/or location. Ongoing consultation between EMEDS medical providers, AF Public Health personnel, AF Entomologists, and US Army Preventive Medicine Officers will be necessary to best determine local anti-malarial needs. The most current Armed Forces Medical Intelligence Center (AFMIC) data and theater Component Surgeon's guidance should be referenced when determining specific risk areas and periods.

2. The following countries have very low or no risk: Iraq, Kuwait, Qatar, United Emirates, Bahrain, Oman, and Jordan. CENTAF sites experiencing low or no malaria risk include Diego Garcia.

3. The table below summarizes the malaria risk by location at **USCENTAF** sites in the following countries.

Location	Treatment Period	Anti-malarials	Terminal Prophylaxis[3]
AFGHANISTAN (CJTF-76)			
Bagram AF	Year-round[5]	Yes[2]	Yes
Kandahar AF	Year-round[5]	Yes[2]	Yes
All areas bordering Pakistan	Year-round	Yes[2]	Yes
PAKISTAN			
All areas	Year-round	Yes[2]	Yes
KYRGYZSTAN			
Manas-Ganci AB[6]	No risk	No	No
TAJIKISTAN[7]			
Dushanbe	May-Oct	Yes[1]	Yes
TURKMENISTAN[8]			
Ashgabat	Apr-Sept	Yes[1]	Yes
YEMEN (all except Sanaa)	Year-round	Yes[2]	Yes
HORN OF AFRICA (CJTF-HOA) (Djibouti, Ethiopia, Eritrea, Somalia, Kenya, Seychelles, and Sudan)	Year-round	Yes[2]	Yes
SAUDI ARABIA[4] (many areas)	No risk	No	No
EGYPT[9] (discrete areas only)	June - Oct	Yes[1]	Yes

[1] Chloroquine is the primary malaria chemoprophylaxis drug of choice. Doxycycline, 100 mg per day beginning 2 days before exposure continuously through the 4 weeks after permanent departure from the malaria risk exposure area, may be used in patients allergic to chloroquine.

[2]Mefloquine remains the primary anti-malarial of choice for non-flying personnel assigned to any malaria risk area in USCENTAF AOR, **except** Iraq, for 24 continuous hours or more during the malaria treatment period. Doxycycline is the drug of choice for personnel on flight status in Chloroquine-resistant areas. Routine use of Doxycycline for malaria prophylaxis of *non-flying* personnel is not recommended.

[3]Relapsing forms of malaria (i.e., *P. vivax*) exist throughout USCENTAF AOR. Terminal prophylaxis with Primaquine should be considered for personnel operating in malaria risk areas, 15mg/day for 14 days, after permanently leaving malaria risk area. {CDC dosage recommendation is not advised}

[4]In Saudi Arabia, malaria is endemic in the southern provinces and the rural areas of the western provinces year-round. Indigenous adult populations are chronically infected and appear relatively asymptomatic. Chloroquine resistance is fairly common, therefore alternative chemoprophylaxis is recommended for these areas. Eastern, Northern, and Central provinces are risk free.

[5]To mitigate potential malaria risks of personnel during the typical rotation period (Jan-Feb) and to achieve parity with Sister Service/CJTF-76 guidelines, *all personnel supporting CENTAF OEF operations must pre-medicate and deploy with sufficient malaria chemoprophylaxis to last the duration of their deployment due to the potential year-round malaria risk exposure.* AFMIC indicates the highest period of risk is Mar-Dec; however, CJTF-76/CC requires malaria chemoprophylaxis throughout the entire year. [CJTF-76/SG cites three epidemics since 1999 have occurred as late as Nov in areas near Kandahar and the season actually extends into Dec. In 2003, one case occurred in Bagram in Dec after the individual was in the area for only 11 days. In Dec 05, mosquito activity was noted by Air Force personnel in Bagram.].

[6]Known high-risk malaria areas in Kyrgyzstan include border areas with Uzbekistan and Kazakhstan. Manas AB is currently considered a non-malaria risk area year round.

[7]In Tajikistan, malaria risk areas exist throughout the country, primarily in the southwestern areas from April through October.

[8]In Turkmenistan, malaria risk areas are predominantly located in the east and southeast from April through September.

[9]Small foci in 2 discrete rural areas of Al Fayyum Governorate and potentially other small foci along the Nile River present seasonal malaria risk. Indigenous adult populations are chronically infected and appear relatively asymptomatic. Other areas are at very low to no risk.